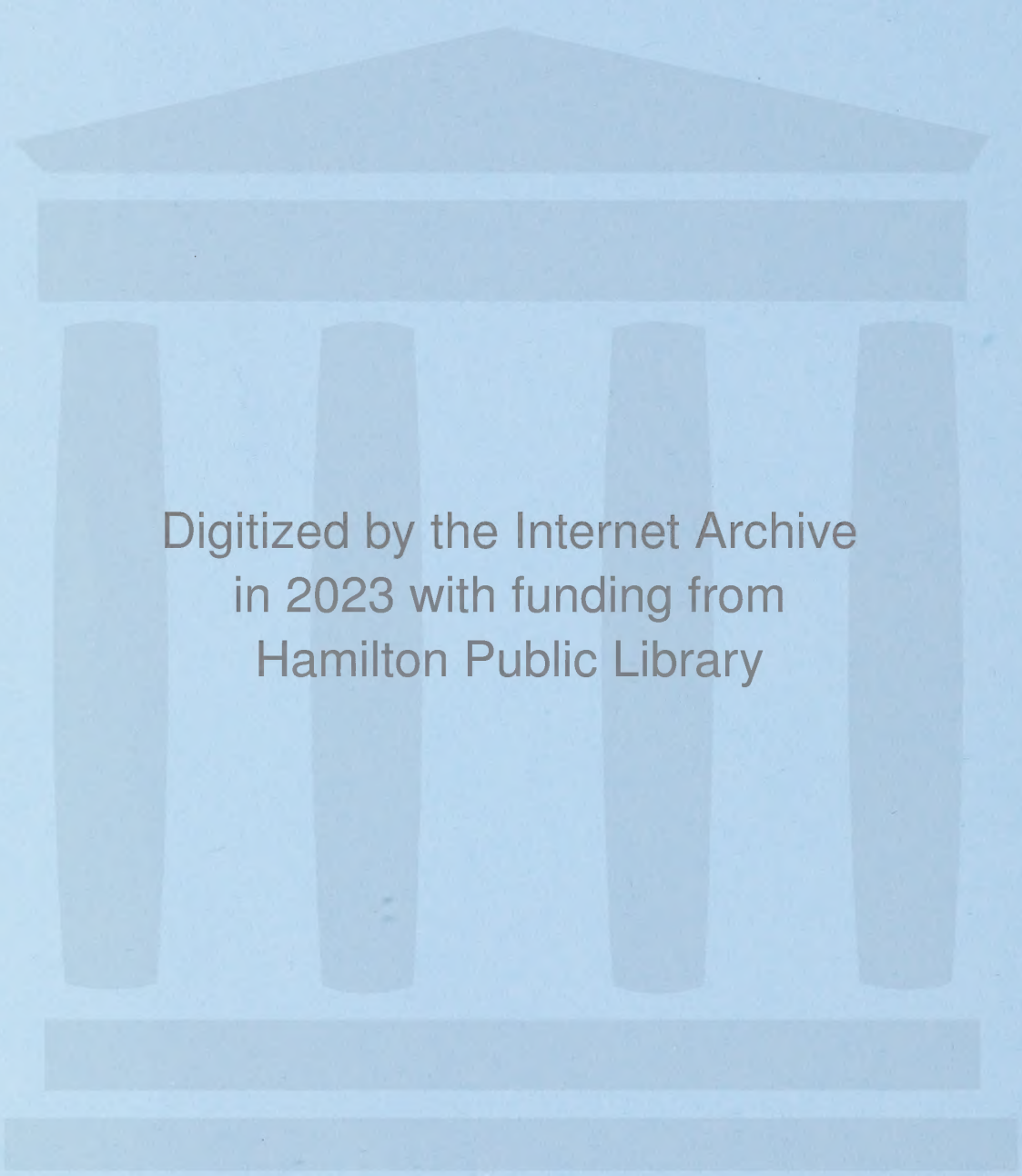
ANNUAL REPORT

Assessment and Placement Service

Hamilton, Ontario

APS

1980–81



NINTH ANNUAL REPORT

OF THE

ASSESSMENT AND PLACEMENT SERVICE

HAMILTON, ONTARIO

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HISTORICAL BACKGROUND

The A.P.S. was established by the Hamilton District Health Council in 1971 on the advice of the then newly formed Extended Care Committee. The project was funded in April of that year by the Ontario Ministry of Health and commenced operation in September 1971.

One of the concerns of the Health Council has been the promotion of optimal utilization of the services for the disabled and chronically ill. The Extended Care Committee was formed to study the needs of this group and the services available. The result of their discussions was the recommendation that a coordinating body be formed to obtain the medical, social and nursing evaluations of the disabled and chronically ill and make recommendations of the appropriate programs or levels of care for the development of the individual's assets and potential.

The Health Council appointed a medical consultant and two members of the health professions to provide the coordinating evaluation function; a part-time administrator and secretarial staff; and a data analyst to maintain statistics for the evaluation of the service's efficacy and the provision of an information base for future planning in the health needs of the disabled.

ASSESSMENT FORM

Prior to commencement of operation an Assessment tool was developed to provide the necessary information for appropriate recommendation. Broadly, this information falls into three categories:

(a) demographic (age, sex, marital status, next-of-kin, education, employment and cultural background, present location and level of income)

(b) medical (diagnosis, prognosis, treatment, level of cognitive function, emotional status)

(c) functional capacity (degree of ability to walk, talk, see, hear, comprehend, dress, bathe, undertake personal care and household care.)

The demographic and functional capacity data is provided by a social worker-nurse team for the hospitalized applicant and by the Public Health, Victorian Order or St. Elizabeth Nurse for those applicants at home. The medical information is provided by the applicant's personal physician.

RECOMMENDATIONS

Recommendations are made on the basis of the information provided by the Health Care team with additional input as indicated and with an intimate knowledge of the available facilities and programs.

Recommendations include appropriate level of care, and/or programs of rehabilitation or recreation, and programs whereby the disabled person may be assisted toward a meaningful role in society.

REFERRAL PROCESS

Referrals are made by health professionals in the community or health care institutions and/or members of the community, and may be as simple as a telephone call asking for the process to be set in motion.

MEDICAL CONSULTANT'S REPORT

- J.R.D. Bayne, M.D., F.R.C.P. (C), F.A.C.P. -

The Assessment and Placement Service (A.P.S.) was established in September 1971, and is now in its tenth year of operation. During that time it has dealt with 18,000 referrals. Basic information on the health and social status of each person was obtained in order to establish the type of care needed and the possible and preferred locations of placement. Individual names are maintained on an active list until either a placement is effected, the request for placement is withdrawn, health status changes or death occurs. The accuracy of information is confirmed (1) by the fact that on follow-up over 90% of those who respond deem the placement satisfactory. Moreover, a research study (2) confirmed that the services available in the facility used did "match" the services deemed to be required by the person when referred.

The basic information obtained on referral is useful also for planning purposes. Although many facilities maintain their own "waiting lists", most of these persons have been referred through A.P.S., especially those with greater care needs. Therefore, the data available from A.P.S. are useful for identifying the deficiencies in amount and kinds of services. We have previously (3,4) pointed out the need for more chronic hospital units, and also for residential care for young disabled persons and special programs and protective services for persons with impaired mental function.

In the past year the Ministry of Health has responded to a request from the Hamilton District Health Council for an increased number of chronic hospital services that was based on the data from A.P.S. There are now two chronic care units in Chedoke-McMaster Hospital - a 35 bed unit at Chedoke and a 34 bed unit at McMaster Division. A further 30 bed unit will open in 1981 at St. Joseph's Hospital. Admission to all these units and St. Peter's Centre is through referral to A.P.S. to ensure balanced use and accessibility to the entire community.

As described in the 1979 A.P.S. report (5), categories of need were identified within the chronic hospital care group, and individuals in such categories have special requirements. One category includes persons living at home and cared for by a family member, often at considerable personal sacrifice and devotion. Such persons are frequently assisted by the Home (Chronic) Care service but occasional relief is needed for the care-giver. Each of the chronic care units takes part in providing for short term admission of those persons who on assessment are found to belong in this category and, by arrangement with the family and the personal physician, agree to discharge when the planned time is up.

The presence of several chronic care units in the general hospitals is tending to alert hospital staffs to the needs of the chronically disabled persons and can be expected to improve quality of care and prevention of disability in the patients in general. The Geriatric-Psychogeriatric Assessment Units at Chedoke Division and the Day Therapy Centre at St. Peter's are growing and allow for better diagnosis, assessment, management, functional evaluation and support for persons who could live at home. The chronic care service of the Home Care Program has shown steady growth since it was started under the administration of the V.O.N. in 1975 and it now has a case load of 1200. It can be expected that this will have an impact upon the numbers of persons seeking residential care.

The A.P.S. was originally set up as a Demonstration Model. It showed that it was possible to obtain information from practicing physicians, nurses, social workers and other professionals of sufficient accuracy to enable the type of care required to be identified. It was possible to identify the kind of facility available that could meet the needs and to assist in gaining access so that there was a degree of fairness and coordination in placement. It was possible to enable placement to occur not only from the general hospital into long term care facilities, but also from the community and from institutions into community programs or into the appropriate institutions. The Service was duly evaluated (6). A service of this kind was recommended by the Ontario Council on Health in its report "Health Care of the Aged 1978".

The Ontario Ministry of Health is now in the process of establishing Placement Coordination Services (P.C.S.) based on the experience of A.P.S. The important role of the P.C.S. is to ensure the relevance of the information provided by professionals and to aid their communication with each other while at the same time providing information for both patient and professional to select appropriate resources.

Thus, by its tenth year, A.P.S. has proven its value. It has been reviewed and its structure re-defined for use throughout the province.

References:

1. Bayne J.R.D. & Caygill J.: Identifying Needs & Services for the Aged, J. Am. Ger. Soc. XXV No.6:June 1977.
2. Dear M, Fotheringham B. Hayes M: Assigning Service Dependant Elderly to Appropriate Treatment Settings: McMaster University Office on Aging 1:May 1979.
3. A.P.S. Annual Reports: Administrator's Reports: 1976-1980.
4. A.P.S. Annual Report: Medical Consultant's Report: 1979-80.
5. Ibid.
6. Woods, Gordon & Co., Assessment & Placement Service Review of Operations: November 1976.

ADMINISTRATOR'S REPORT

Joyce Caygill

The material used for this Report was collected during the fiscal year April 1, 1980 to March 31, 1981.

The numbers of persons referred to A.P.S. increased slightly during 1980-81, although the average number waiting at any time decreased. The monthly census is reprinted elsewhere in this report in order to show the gradual decline in waiting list numbers as the year progressed. Thirty-five new chronic care beds were introduced in September 1980, which helped to relieve the pressure throughout the system.

Last year we made reference to the number of young adults who are both severely disabled and mentally retarded for whom appropriate services are not available in this area. During 1980-81, twenty of these young adults were referred to A.P.S. by Rygiel Home. Most of these twenty were placed when young children; however, as each reached the Rygiel age limit of 18, adult facilities were not available and so they remained at Rygiel. Unfortunately, the inability of this community to provide for such young adults creates a "log jam" preventing the admission to Rygiel of children who could benefit from the developmental programs offered there.

It is anticipated that the number of young residents of Rygiel reaching the age of adulthood (18) will increase each year.

During 1980-81, A.P.S. also monitored the number of persons whose care needs exceeded the usual care given in a chronic care facility, and who therefore required maintenance in an acute care setting. We have used the term "Life Support" to describe the needs of these patients. Nine persons required this type of care during the year.

Once more it is necessary to mention the lack of specific programs for the confused, ambulant elderly and the person with pre-senile dementia. Some homes for the aged provide accommodation specifically for these elderly persons; however, the bed capacity is limited. Table VI relates to this issue.

DATA BASE

Criteria for inclusion in the data base for this Report were as follows:

- Parts A and B of the A.P.S. referral form had been completed by the attending health professionals.

- the care needs identified by attending health professionals had been "matched" with care provided in various programs and a recommendation of the appropriate program had been made and recorded by A.P.S.

- either placement, death, refusal of placement, change of condition or refusal of patient by a program had occurred to close the case.

Two thousand one hundred and ninety-nine cases fulfilled these criteria and were used for the majority of the information in the Report.

REFERRALS

During the 1980-81 fiscal year we were involved with 2,966 cases, an increase of 314 over the previous year and our highest recorded number to date. 2,306 cases were referred during the 12 month period, 660 were transferred unplaced, from the 1979-80 caseload. 422 cases which were unplaced at year end were transferred to the 1981-82 waiting list. The 345 cases which were not transferred to the current waiting list and are not included in the date base either decided against placement or died before a recommendation could be made.

WAITING LISTS

The waiting list has shown a remarkable decline since the beginning of the 12 month period. Additional beds in the system have been limited to an additional 35 chronic care beds at the Chedoke-McMaster Hospital. Table I shows the total number awaiting placement at the time of the monthly census of A.P.S. statistics. Comparison with data from previous years shows that the average number awaiting placement, 615, is the lowest figure since 1976 when a monthly average of 540 awaited placement, (1977 -- 617; 1978-79 -- 643; 1979-80 -- 672).

Average high and low months for previous years are as follows:

high -		low -	
	July 75		March 75
	Dec 76		July 76
	Dec 77		July 77
	Oct 78		March 79
	Nov 79		April 79
	May 80		March 81

PLACEMENTS

Two hundred and eighty-three persons included in the data base died before placement, 599 refused placement when offered, 182 underwent a change of condition, 61 were refused admission to a program.

Table II shows that, in general, more persons appeared to require institutional based programs than were placed. The notable exception to this is in Home Care, home support and lodging house placements. In the previous two years we found that some persons for whom institutional recommendations were made were able to manage at home with home delivered programs. In 1980-81 A.P.S. recorded 48 persons who chose this type of care, which compares favourably with 27 in 1979-80 and 28 in 1978-79.

Twenty of the persons who were refused admission to programs are those young adults living at Rygiel Home, 9 were life support patients who remained in active treatment hospitals, 4 were not accepted by homes for the aged, 20 were not accepted by day programs and seven were not appropriate for chronic care programs.

In all 61 of these cases the programs to which these patients were offered were known by A.P.S. to be inappropriate; however, suitable alternatives did not exist and it is A.P.S. policy to request that, whenever possible, programs be modified to accept clients. In many instances modifications can be made; however, for the 61 under discussion it was not possible.

TYPES OF CARE REQUIRED

Table V shows the ages of persons in the data base.

Table VI shows the assessing health professionals records of ambulation and memory. A.P.S. usually considers a person to be "confused, ambulant" when confusion is recorded at level 4 or 5 (marked confusion, no recall), ambulation is recorded at levels 1 to 3 (fully ambulatory, ambulant with cane, independent with a wheel-chair). 285 persons in the data base were in this category.

492 referrals were completed by hospital residents or interns, 399 general practitioners completed the remainder. One physician completed information on thirty-four of his patients.

179 persons had been in active treatment twice within the previous 12 months; 63 had been admitted 3 times; 18 had had four admissions; 11 had been in hospital between 5 and 7 times in the immediately preceding 12 months.

318 persons were referred to A.P.S. by family members, 309 by friends and others, 163 by physicians, 883 by hospital teams, 512 by visiting nurses; missing data: 14. 59% of referrals were from the community.

841 (38%) were male; 1358 (62%) were female. 1089 persons were widowed, 269 were single, 94 divorced or separated, 667 married; missing data: 80. Forty-seven persons could not speak English (2.1%).

39 persons required oxygen; 161 had indwelling catheters; 106 required sterile dressings; 36 required intravenous feeding.

731 required assistance during the night. 464 had limited to poor vision; 26 were blind. 425 had partial to poor hearing; 17 were deaf.

374 persons lived with their children at the time of referral; 18 lived with parents.

1163 persons did not smoke; 218 expressed an interest in having alcoholic beverages available on an occasional or regular basis.

CLIENT SATISFACTION

A.P.S. conducts a follow-up by mail and/or telephone four to six weeks following placement. Of the 1074 persons who were placed in 1980-81, 760 responded as follows:

Client/family satisfied	Yes: 725	No: 35	
Facility satisfied with client	Yes: 752	No: 5	(missing: 3)
A.P.S. Counsellor satisfied	Yes: 726	No: 21	(missing: 13)

"No" responses are checked immediately by A.P.S. to determine the cause of dissatisfaction and to effect changes if possible.

IDENTIFICATION OF NEEDS IN THE COMMUNITY

Throughout this Report mention has been made of several groups of persons with specific care needs. Since 1976 these Reports have referred to the shortage of appropriate services for the confused, ambulant elderly and those with pre-senile dementias. 1980-81 saw no change in the need for these services.

Similarly, we have reported upon the need for Type 2 care for young adults; again, no changes.

Now, as a community, we are faced with the need for Type 3 services for young adults with severe physical and mental disabilities. This is a compounding situation because the lack of such services prevents the admission of young children to a program which would assist them, and their families, during the early, formative years. Until an

appropriate service can be developed for the young adults now resident at Rygiel Home they will continue to occupy beds and block the admission of children equally severely disabled.

The development of respite programs at all chronic care facilities to provide relief for caregivers has been accepted enthusiastically by the public and health professionals alike. During respite admissions many patients have been able to benefit from intensive reactivation programs designed to develop physical or mental potential. Almost without exception follow-up letters express glowing thanks.

Chronic care facilities request two months advance notice for respite and advise families not to make personal arrangements until the respite dates have been confirmed. However, in emergency circumstances such as illness of the caregiver, chronic care facilities have acted with compassion and made every effort to accommodate the patient.

ACKNOWLEDGEMENTS

We continue to enjoy the support and cooperation of the providers of health care in this area, and of McMaster University Computation Services Unit. We gratefully acknowledge their contribution to the continued operation of our service.

TABLE I

MONTHLY CENSUS OF WAITING LIST

	Waiting list at Monthly census	Number awaiting Nursing Home	Number awaiting Chronic Care *
April/80	660	259	122
May	691	272	135
June	658	256	121
July	653	232	140
Aug.	629	225	132
Sept.	672	242	141
Oct.	684	259	130
Nov.	623	239	110
Dec.	557	209	107
Jan/81	527	167	123
Feb.	542	169	146
March	489	134	99

* does not include those awaiting family assistance/vacation/respite.

TABLE II

RECOMMENDATION & PLACEMENT

Number of places required		Number placed
Hamilton - chronic	147	227
Halton - chronic	33	6
other areas - chronic	11	8
*Family assistance - chronic	65	55
Life support	9	
Hamilton - nursing homes	849	322
Halton - nursing homes		41
other areas - nursing homes		28
Homes for aged - normal	381	370
- special	84	14
- bed	15	16
- couples	24	6
* - vacation	6	6
Lodging Home	54	95
Home Care	19	63
other home supports	5	13
Day centres	146	80
Rehabilitation - Hamilton	4	5
- Halton	5	1
Other	42	18
TOTAL	2199	1074

* Various names for respite beds.

EXPLANATION OF DIAGNOSTIC GROUPINGS

(see TABLE [redacted])

In view of the fact that it is usually the physical care needs that determine the type of care a patient requires from a program in long term care, the diagnoses have been grouped to provide a "picture" of the disease states of persons referred to A.P.S. Groups are as follows: code numbers relate to the coding system "International Classification of Diseases adapted for American use" (ICDA-8).

"Conditions related to cerebral dysfunction" - CVA, senile and pre-senile dementia, cerebral arteriosclerosis, cerebrovascular disease, senility, organic brain syndrome, affective psychoses. (Codes: 290-299, 344, 432-438, 794).

"Conditions related to cardiac dysfunction" - rheumatic heart diseases, hypertensive heart disease, ischemic heart disease, arteriosclerotic heart disease, congestive heart failure, etc. (Codes: 391, 393-398, 402, 410-429).

"Conditions classed as arthritis" - osteoarthritis, rheumatoid arthritis, arthritis, rheumatism. (Codes: 710-718).

"Hypertension" - (Code: 401).

"Conditions related to respiratory dysfunction" - emphysema, asthma, bronchitis, chronic obstructive lung disease, pneumonias. (Codes: [illegible].

"Diabetic conditions" - (Code: 250).

"Neoplastic diseases" - (Codes: 200-209, 140-199).

"Hip fractures" - (Code: 820).

"Arteriosclerosis" - (Code: 440).

TABLE III

DIAGNOSIS

Number of diagnoses recorded 5750

Average number of diagnoses per referral 2.6

N = 2199

	Diagnosis	Absolute frequency	Percentage of
1.	Conditions related to cerebral dysfunction	[illegible]	[illegible]
2.	Conditions related to Cardiac dysfunction	[illegible]	[illegible]
3.	Conditions classed as arthritic	[illegible]	[illegible]
4.	Hypertension	[illegible]	[illegible]
5.	Conditions related to respiratory dysfunction	[illegible]	[illegible]
6.	Diabetic conditions	[illegible]	[illegible]
7.	Neoplastic diseases	[illegible]	[illegible]
8.	Hip fractures	[illegible]	[illegible]
9.	Arteriosclerosis	[illegible]	[illegible]
		[illegible]	[illegible]

TABLE IV

LOCATION AT TIME OF REFERRAL

HAMILTON-WENTWORTH	
Henderson Hospital	209
Hamilton General Hospital	161
St. Joseph's Hospital	198
*Chedoke Division	101
*McMaster Division	87
St. Peter's Hospital	24
Hamilton Psychiatric Hospital	24
Rygiel Home	20
Community	1150
HALTON	
Hospitals	125
Community	53
ONTARIO	
Hospitals	30
Community	19
CANADA	4
OUTSIDE CANADA	1
[illegible]	4
TOTAL	2199

*Locations of Chedoke-McMaster Hospital.

TABLE V

AGE AT TIME OF REFERRAL

	1980-81	1979-80	1978-79
5 - 9	0	1	17
10 - 14	1	3	
15 - 19	11	7	
20 - 24	19	4	
25 - 29	13	7	14
30 - 34	13	8	
35 - 39	5	6	29
40 - 44	10	11	
45 - 49	19	17	58
50 - 54	50	42	
55 - 59	49	39	165
60 - 64	108	104	
65 - 69	192	118	439
70 - 74	258	193	
75 - 79	376	330	745
80 - 84	480	378	
85 - 89	378	295	437
90 - 94	148	129	
95 - 99	51	40	
100 - 104	12	9	
Missing data:	6	21	143

TABLE VI

MEMORY AND AMBULATION

AMBULATION	NORMAL 1	[illegible] 2	PERIODS OF CONFUSION 3	MARKED CONFUSION 4	NO [illegible] 5	ROW TOTAL
Fully 1	1[illegible]	[illegible]	[illegible]	137	[illegible]	[illegible]
Ambulatory with cane 2	108	159	88	45	3	403
With wheelchair 3	88	77	71	33	13	282
Requires assistance 4	89	169	161	[illegible]	[illegible]	591
Immobile 5	[illegible]	[illegible]	51	55	[illegible]	[illegible]
Row Total	[illegible]	[illegible]	546	410	137	[illegible]

Missing observations: 59

TABLE VII

FIVE YEAR COMPARISON OF WAITING LISTS FOR THE MONTH OF NOVEMBER

In institutions awaiting placement

Facility required	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Nursing Homes	101	57	[illegible]	181	[illegible]
Chronic Hospitals	66	88	116	95	80
Homes for the Aged	30	40	19	31	30
Rehabilitation Units	6	3	[illegible]	[illegible]	[illegible]
Community Services	19	16	[illegible]	[illegible]	[illegible]
Other	[illegible]	10	[illegible]	[illegible]	[illegible]
Total in hospital	251	314	286	284	239

In the community awaiting placement

Facility required	1976	[illegible]	[illegible]	[illegible]	[illegible]
Nursing Homes	130	108	[illegible]	[illegible]	[illegible]
Chronic Hospitals	51	[illegible]	[illegible]	[illegible]	[illegible]
Homes for the Aged	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Rehabilitation Units	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Community Services	[illegible]	23	[illegible]	[illegible]	[illegible]
Other	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Total in community	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Total awaiting placement	579	613	678	750	580

OPERATING EXPENSES

	Year end - *March 31/80	*March 31/81
Salaries **	102,739	113,427
Employee benefits	9,883	11,986
Space costs & services	11,220	11,220
Advertising (staff)	--	--
Insurance	271	244
Business Machine Expense	175	272
Postage	1,836	1,504
Office supplies	4,069	4,844
Telephone	2,919	2,563
Travel	1,572	1,524
Data processing	2,218	3,304
Staff training	130	85
Equipment	1,503	(11)
Other	98	48
Audit ***	300	300
	138,933	151,310

* figures prior to audit
** includes accrued staff benefits for vacation & sick leave
*** estimated audit fee

TYPES OF CARE

(extract: Patient Care Classification by Types of Care, Ontario Ministry of Health publication #75-2222 8/75, pp3-4)

TYPE 1 (RESIDENTIAL CARE)

Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

TYPE 2 (EXTENDED HEALTH CARE)

Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 3 (CHRONIC)

Care required by a person who is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 4 (SPECIAL REHABILITATIVE CARE)

Care required by a person with relatively stable disability such as congenital defect, post-traumatic deficits of the disabling sequelae of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this TYPE OF CARE is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

TYPE 5 (ACUTE)

Care required by a person:

a) who presents a need for investigation, diagnosis or for definition of treatment requirements for a known, an unknown, or potentially serious condition; and/or

b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or

c) who is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.

TERMINOLOGY IN COMMON USE IN ONTARIO

TYPE 1 CARE

Where provided

Homes for the Aged
Charitable institutions
Nursing homes
Foster homes
Group homes
Boarding homes
Homes for special care (residential care)
Children's institutions
Homes for unmarried mothers

Terminology

Domiciliary care
Ambulant care
Normal care
Residential care
"Intermediate care" in nursing homes
Community (social) support programs
(mental)
- day care
- sheltered workshops
- supervised recreation

TYPE 2 CARE

Where provided

Homes for the Aged
Nursing homes
Homes for special care (nursing homes)
Children's institutions

Terminology

Extended health care
Extended care
Homes for special care programs

TYPE 3 CARE

Where provided

Chronic hospitals
Chronic care units in general hospitals
Nursing homes approved for chronic care
Geriatric units in psychiatric hospitals
Special facilities (schedule II) for mentally retarded with physical handicap
Children's institutions

Terminology

Chronic care
Care of the chronically ill
Chronic hospital care
Psycho-geriatric units (psychiatric hospital)

TYPE 4 CARE

Where provided

Regional rehabilitation centres

Terminology

Special rehabilitation care
Rehabilitation

TYPE 5 CARE

Where provided

Public hospitals
Private hospitals
(G.H.P.U.) psychiatric units of general hospitals
Provincial psychiatric hospitals
Private psychiatric hospitals
Community psychiatric hospitals
Children's mental health centres

Terminology

Acute care
Active treatment
Psychiatric care (short and medium term)

NOTES

Data was accessed using the Statistical Package for the Social Sciences (SPSS) software package on the HP 3000 of McMaster University Computation Services Unit.

Codes include:

Diagnosis	ICDA - 8 (International Classification of Diseases adapted for American use)
Location by facility	Ministry of Health Ministry Information System Division Data Development & Evaluation Branch Master Numbering System
Location by area	Ontario Postal Region Code
Physician	Medical Directory of the College of Physicians & Surgeons of Ontario

Mailing address for the Assessment & Placement Service:
Box 2085, Hamilton, Ontario
L8N 3R5

Telephone: (416) 385-5361